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Date_____

HEALTH HISTORY

Patient's Name_____
(first) (last)
Birthdate_____ Boy Girl (please circle)
Patient's Physician_____ Phone_____
Address_____ Date last saw physician_____
Patient's Specialist_____ Phone_____

Is/Has Child:	Yes	No	If yes:
Any illness now?	☐	☐	Type_____
Receiving any medications or drugs?	☐	☐	List_____
Ever been hospitalized?	☐	☐	Date_____
Ever had surgery?	☐	☐	Date_____
Allergic to any medications?	☐	☐	List_____
Allergic to latex products?	☐	☐	List_____
Are there any other allergies?	☐	☐	List_____
Born Premature or Low Birthweight?	☐	☐	Explain_____

Has/Had any history of:

(please circle)

Anemia	Y	N	Hearing Problem	Y	N	Rheumatic Fever	Y	N
Asthma	Y	N	Heart Problem	Y	N	Sleep Apnea	Y	N
Autism	Y	N	Heart Murmur	Y	N	Tuberculosis	Y	N
Bleeding Disorder	Y	N	Hepatitis	Y	N	Tumors/Cancer	Y	N
Diabetes	Y	N	HIV/AIDS	Y	N	Special Needs/Other:_____		
Emotional Problem	Y	N	Kidney Disease	Y	N	_____		
Epilepsy/Convulsions	Y	N	Liver Disease	Y	N	_____		
Fainting or Diziness	Y	N	Mental Disorder	Y	N	_____		

DENTAL HISTORY

Reason for this appointment_____
How do you feel about the condition of your child's mouth and teeth?_____
Date of last visit_____ Name of former dentist_____
Treatment provided_____

Has Child:	Yes	No	If yes:
Complained about dental problems?			_____
Has had an unhappy Dental Experience?			_____
Had any injuries to mouth, teeth or head?			_____
Had nursing, bottle feeding or bottle habits continue beyond 18 months of age?			_____
Had any mouth habits such as thumbsucking, nail-biting, mouth breathing, pacifier, etc.?			_____
Is Fluoride taken in any form?			_____
Had adverse reaction to anesthetics?			_____
Child's attitude toward dentistry			_____

Parent or Guardian Signature_____**Relationship to Child**_____ **Date**_____

Reviewed by Dr. R.K. Dail on_____